Long Term Care Coordinating Council

Minutes of the meeting held Wednesday, June 13, 2018

Child and Family, Main Conference Room, 1268 Eddy St., Providence, RI 02905

Attendance:

Angelo Rotella	Holly Garvey	Kelly Lee	Michael Cronan	Rita Towers
Bonnie Sekers	Jaclyn Pofilio	Kelsea Dixon	Michelle Brophy	Sam Zwetchkenbaum
Brenda DuHamel	Jaimie Furtado	Laurie Ellison	Michelle Szylin	Sarah Neil
Brittany Gilligan	Jim Nyberg	Laurie Mantz	Mike Walker	Stephanie Rendina
Deborah Burton	John DiTomasso	Lori Light	Mykahla Gardiner	Vicktoria Barokha
Debra Demar	Karen Allsop	Majorie Waters	Nancy Silva	Victoria Goetz
Diane Facha	Karen Statser	Mario Olivieri	Nelia Botelho	
Dianna Shaw	Kathleen Heren	Mary Lou Moran	Nicholas Oliver	
Donna McGowan	Kathleen Kelly	Matt Gendran	Patricia Raskin	
George Sousa	Kathleen Repoli	Maureen Maigret	Rebecca Boss	

Welcome: Meeting called to order by Maureen Maigret at 10:05am. Introductions around the room.

Approval of Minutes of 3/14/18: Motion to approve with corrections by Nicholas Oliver, seconded by Kathleen Kelly. All in favor.
Approval of Minutes of 4/11/18: Motion to approve as submitted by Nicholas Oliver, seconded by Kathleen Kelly. All in favor.

Presentation of New BH Link by Director Rebecca Boss, BHDDH:

See PowerPoint Slides at the end of minutes.

942-STOP substance abuse

Have accessed federal funding. Governor has money in the budget, hoping it is in the finalized budget. Currently accessing a facility. In some negotiations for a facility.

Q: translate the percentage of visit to numbers of people? A: can get the information out to the group.

Q: just Medicaid users or everyone? A: everyone, but will back that up.

Q: age restrictions for program. A: adults. Need to look at the under 18 community needs. They won't be turned away in a crisis, but will be assessed and sent to the right place for assistance.

Q: who Horizon Health Partners? A: A partnership of: Kent Center, Community Care Alliance and Newport Mental Health

Hotlines are not dependent on a facility, hopeful start in July.

Introduction of Mike Splaine of Splaine Consulting: Mike gave a brief introduction of himself and the work he is contracted to do with the Alzheimer's State Plan Update. Week of August 6th calendar of Town Hall meetings will be complete by the end of this week and will be emailed to the LTCCC to share.

Update of the Governor's new LTSS Reform Initiatives by Jaclyn Porfilio:

Handout to be sent out electronically.

May 25th Governor's announcement– broad initiative around LTSS policy reform. Moving toward a person-centered system. Will be moving forward with a phased approach. June 14th Community Roundtables begin. Think Tank on LTSS on Workforce policy options. Phase 2 August – December – series of stakeholder workshops. On the other side will be implementing and addressing issues that were not heard. Increase for direct support service. More senior centers. POINT website. ADRC.

Send schedule of community meetings.

Q: Phase 1 question: workforce policy think tank – more details? A: Rick Brooks will be involved. Taking the longer report and making the policy options to take to phase 2. Targeted to 3-4 meetings to try and prepare for phase 2.

Community Health Network by Kelsea Dixon, DOH:
See PowerPoint slides at the end of minutes.
Q: Would it possible to schedule programs inside healthcare facilities? A: Yes, you can contact RIPIN or Kelsey. Also, some can be employer wellness programs.
Cardiovascular program is growing now with new funding that is coming in.
Patient navigators are Community Health Workers from RIPIN and they develop and train the workforce along with Dept of Health.
Certifying body is Community Health Worker Association of RI
Have had preliminary conversations with Alzheimer's Association. Working on getting the criteria setup and see where Alzheimer's and dementia and behavioral health will fit into program.
Q: How can Alzheimer's be added to the chronic disease list? A: we need to have a program setup.
Alzheimer's Association is pushing to make it happen. Moving in the direction and in negotiation stages.

Transportation Report by Mario Olivieri & Diane Facha:
Slides will be sent out electronically.
Resuming monthly meetings hosted by the Alliance for Better Long term Care due to recent issues; last Wednesday of the month, 10:30am at the Alliance.

ICI Report Distributed. questions to Dawn Allen who was not able to attend meeting:
Please email Craig Dwyer any questions and he will direct them to Dawn Allen for a response, or mail Dawn directly.

Subcommittee Review:

Alzheimer's Executive Board: We have hit the ground running regarding the plan update. August 6th – 23 focus groups being planned. Schedule will be sent to the group once complete. Please pass along to get the word out.

Aging in Community/Healthy Aging: attention has been focused with the legislature. $800k community grant was maintained. Homecare rate increases. Proposal to charge co-pays for people on Medicaid – not included in the budget. Retro-active Medicaid coverage maintained. ADRC language in budget Article. Overall the budget has some terrific things for LTC/older adults.
Tufts Health Plan Foundation Momentum Fund – providing grant $10k to 10 applicants in RI, MA, NH. Aimed at developing age-friendly or dementia-friendly initiatives.
Community Enhancement grants – $500,000 from Money Follows the Person Fund. Hope to hear more when application period announced.
Age-Friendly RI partnering on the Community Conversation in South Kingstown tomorrow to kick off Governor's LTSS reform effort

LGBT Report: no report

Oral Health: May Oral Summit was a great success. Next work is to continue is a senior oral health plan. Need some project management to move forward with the plan. Looking for a student for 6-8 months to help with project management. Subgroup Meeting tomorrow at 3-4pm at the Alliance.
Q: On-site dental program – is there another in the works? A: CareLink is working towards moving in that direction. Looking to expand to more assisted livings and senior housing.
Legislation to expand dental hygienist. Specific training to be completed.
Q: Is there a list of dentists who accept Medicaid payments available? A: Oral Health Website – find a dentist link.

Behavioral Health: Meeting Thursday, June 21 2:30pm, Substance Use and Mental Health

Public Comment:

Alzheimer's Day was a great success, thank you for all who were involved. Golf Tournament on June 21st at Newport Golf Club. Alzheimer's Walk website is up with all information. New walk at Misquamicut beach on Sept 23rd.

Alzheimer's Workforce Development: meets first Tuesday of each month - July 10th at Greenwich Farms

Medicaid Matters meetings – to explain the difference between Medicaid and Medicare – and the benefits of Medicaid. Educational meetings to be offered by RIOP. First meeting is: August 14th Benefit Street Church at 3pm.

Patricia Rasking announced next Blue Cross sponsored meeting is June 13th at the Blue Store in Warwick – Safe Guard your finances. Caregiver Support –

Age Friendly RI Day in May went very well.

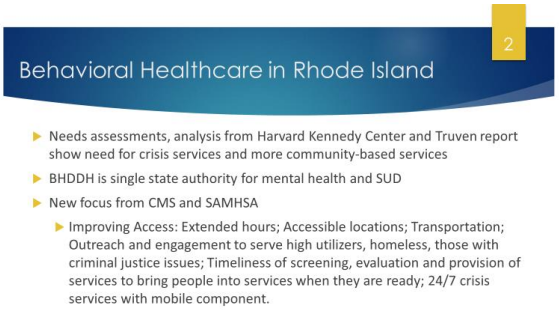
Friday is World Elder Abuse day to bring awareness and address the issue of elder abuse. Saint Elizabeth Community is sponsoring a breakfast in recognition of the day at the Crowne Plaza that day.

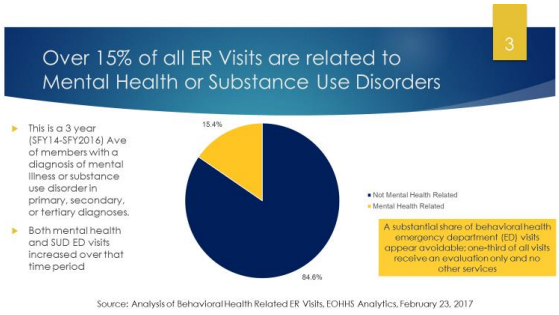
Memory Café in RI – social and educational opportunity – Thursday, June 14th 1pm-2:30pm at Temple Beth El

Next Meeting: September 12, 2018 10:00am at Child & Family

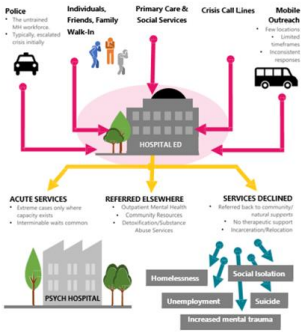
Adjournment: Meeting adjourned at 11:38am by Maureen Maigret.

Respectfully Submitted by Tabatha Dube**,** Office of Lieutenant Governor Dan McKee





Traditional Community Crisis Flow →



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Where's the Choke Point in the Usual Approach?

What is BH Link

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- 24/7 Behavioral Health Crisis Response being implemented by Horizon Health Partners with three major components

1. Physical location triage facility
   a) Clinical services including Rx and pharmacy
   b) Recovery support (peers) and case management
   c) Transportation and linkage to services
   d) 24/7 Face to face assessments
   e) 24/7 phone screening and triage
   f) Nursing and psychiatric assessments
2. Hotlines: Suicide line, State warm line (942-STOP), After hours incident reporting for Developmental Disabilities and Behavioral Health
3. Mobile capacity

Why BH Link?

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Better, More Cost-Effective Behavioral Healthcare in Rhode Island

Current challenges:

- Emergency departments are not only costly, they are often not the right level of care
- Law enforcement and other first responders want to be helpful to people experiencing a mental health or substance use crisis, but don't have easy access to the appropriate resources.
- Access to treatment can be challenging and people looking to get help often do not know where to begin.

The **BH Link Hotline and Triage Center** will connect people to treatment and recovery resources to get better.

- **BH Link** will fill gaps in the current behavioral healthcare system: it will help individuals experiencing behavioral health crises, the families and friends caring for them get access to the care they need.
- **BH Link** will strengthen the State's response to the devastating opioid crisis.
- Crucially, **BH Link** will offer appropriate care for people experiencing a behavioral health crisis.

Besides individuals in need who does this help?

Law Enforcement

Law Enforcement By-passes the Emergency Room and Proceeds Directly to Crisis

Experience of other crisis centers in US:

5 to 7 Minute Turn- Around Police Drop Off.
No Call.
No Referral.
No Rejection.
Simple.

What difference does this type of Crisis Model make?

In the 4-million-person community of Maricopa County (Phoenix, Arizona) the continuum of crisis services has had the following outcomes compared with a community without them.

Their center allowed 37 FTE Police Officers to re-engaged in Public Safety instead of behavioral health transportation/security

A Staggering Reduction in Psychiatric Boarding (aka Waiting in the ED)

Creating a savings to hospitals of **$37 million** in avoided costs/losses

Reduced Potential State Acute Care Inpatient Expense by $260 million

The cost avoidance represents the net savings of a $100 million investment in a full, integrated crisis continuum

Evidence of Financial Savings

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Analysis of top ten Emergency Department utilizers in the State of RI who accessed the RNP program.

- The time period prior to the RNP is 12/1/15 through 11/30/16
- The time period post RNP is 12/1/16 through 4/30/17

Aves were used to compensate for the inequitable timeframes pre and post.

Net Changes In Average ED & IP Rates Post RNP (In Percentages)

ED visits /period	
Ave # ED visits prior to RNP	63/mo
Ave # ED visits post RNP	47/mo
Ave ED Claims $ prior to RNP	$25,472/mo
Ave ED Claims $ post RNP	$19,624/mo
Ave Inpatient stays prior to RNP	3/mo
Ave Inpatient stays post RNP	2/mo
Ave Inpatient claims $ prior to RNP	$10,423/mo
Ave Inpatient claims $ post RNP	$6,478/mo

Source: MMIS claims data over 45 months from 2013 -2017

Thank You!

▶Questions?

RHODE ISLAND DEPARTMENT OF HEALTH

Who are the partners?

CHN compiles program schedules from agencies across the state that coordinate programs, such as:

- Rhode Island Department of Health (RIDOH)
- Rhode Island Parent Information Network (RIPIN)
- Healthcentric Advisors
- The YMCA of Greater Providence
- Own Your Health

Community Health Network

Your connection to low-cost health programs

June 13, 2018
Long Term Care Coordinating Council

Who Refers Into CHN?

- Primary Care Providers
- Health Insurance Companies
- Community Partners
  - Senior Centers
  - Rhode Island Parent Information Network
  - Community Action Program Agencies
- Caregivers, Friends, and Family Members
- Self-Referrals

Centralized Referral System

Evidence-based self-management and prevention programs for individuals with chronic conditions or health concerns such as:

- Arthritis
- Asthma
- Prediabetes/Diabetes
- Heart Disease
- High Blood Pressure
- Cancer
- Pain
- Tobacco Use
- Fall Risks
- Caregiver Burnout
- And more!

Why Use CHN?

RI Chronic Illness and Health Concern Prevalence

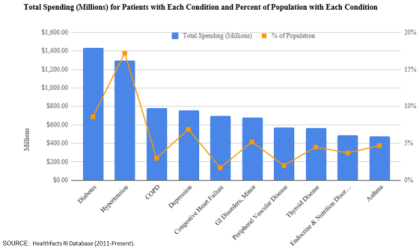
- Among RI adults 18 and older, 56% have a chronic disease*.
- 26% have 2 or more chronic diseases to manage.
- Of RI registered voters aged 45+, 58% have been caregivers to an adult loved one.
- In 2016, the prevalence of cigarette smoking among adults in Rhode Island was 14.4%.

*Hypertension, diabetes, asthma, arthritis, COPD, or cardiovascular disease.
SOURCE: 2015 & 2016 RI BRFSS; 2017 AARP/Rhode Island Caregivers Survey

Why Use CHN?

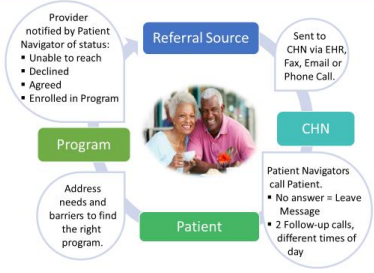
Chronic Illness Burden

Total Spending (Millions) for Patients with Each Condition and Percent of Population with Each Condition



SOURCE: Healthfacts RI Database (2011-Present).

CHN Workflow



Continuous Quality Improvement

- **To increase patient success in programs, we are aware of and working on:**
  - Frequency and quality of communication between:
    - Patient Navigator and Provider
    - Program and Provider
  - Increasing enrollment and program availability
  - Continuing education for program facilitators: Engagement, retention, adherence
  - Widening the range of programs available
  - Open to other suggestions

Menu of Programs

- Asthma Services
- Certified Diabetes Outpatient Educator (CDOE)
- National Diabetes Prevention Program
- EnhanceFitness Program (YMCA)
- Matter of Balance: Managing Concerns About Falls
- Powerful Tools for Caregivers
- Self-Management Education Programs:
  - Diabetes Self-Management Program
  - Tools for Healthy Living (Chronic Disease Self-Management Program)
  - Chronic Pain Self-Management Program
- Tobacco Cessation Services
- WISEWOMAN

Menu of Programs

18+ adult group classes* of 15-20 people are:

- Held year-round
- Offered statewide
- Evidence-based
- Offered in English and Spanish
- Many are free or low cost
- Designed to be engaging, fun, and meaningful

For calendar and details:
www.ripin.org/events/category/community-health-network/

*Asthma Services are designed for children with asthma and their parents/caregivers.

Asthma Services

Aims to reduce asthma related hospitalizations, emergency room visits, and missed days of work and school.

- Eligibility: Families with children who have asthma living in Providence, Woonsocket, Central Falls, and Pawtucket.
- Up to three sessions to learn how to manage your/your child's asthma.
- May include home visits by a Certified Asthma Educator; support for healthy housing, tenant rights, and social services; or coordination of care with primary care providers, school nurses, teachers, and caregivers.
- Cost: Free

Coordinated by RIDOH

Certified Diabetes Outpatient Educators (CDOE)

Helps educate and empower people affected by diabetes to adopt healthy self-care behaviors to manage their nutrition, glucose, blood pressure, cholesterol and medication

- Eligibility: Diabetes diagnosis
- Registered Nurses, Dietitians, and Pharmacists certified in diabetes outpatient education.
- Individual or group consultations in provider offices or CDOE sites
- Cost: Covered by most private insurance plans, may require

Coordinated by RIDOH

Chronic Pain Self-Management Program (CPSMP)

Provides participants with the tools to manage medications, fatigue, frustration, proper nutrition, and communication skills, and teaches evaluation of treatments and creation of action plans.

- Eligibility: Anyone 18 years old or older.
- Led by two certified peer leaders in group sessions.
- Sessions run for 6 weeks at 2.5 hours per week.
- Cost: Free

Coordinated by Own Your Health

Diabetes Self-Management Program (DSMP)

Helps people diagnosed with diabetes, pre-diabetes, family members or caregivers to manage their symptoms focusing on healthy diet choices, meal planning, incorporating physical activity, tools to deal with fatigue, pain, high/low blood sugars, stress, emotional health and depression.

- Eligibility: Individuals with diabetes, pre-diabetes, or status as a caregiver or loved one for someone with diabetes
- Led by two certified peer leaders in group sessions
- Meets for 6 weeks, 2.5 hours per week
- Cost: Free

Coordinated by Healthcentric Advisors

National Diabetes Prevention Program (NDPP)

Teaches adults with pre-diabetes, or at-risk of developing type 2 diabetes, to lower their risk by improving nutrition and physical activity.

Eligibility guidelines:
- 18+ years old with a BMI > 25 or > 23 for Asian Americans.

AND

- Have a blood test result in the prediabetes range within the past year:
  - Hemoglobin A1C: 5.7-6.4 or
  - Fasting plasma glucose: 100-125 mg/dl or
  - Two-hour plasma glucose (after a 75gm glucose load): 140-199mg/dl

OR

- Clinically diagnosed Gestational Diabetes Mellitus (GDM) during a pregnancy

OR

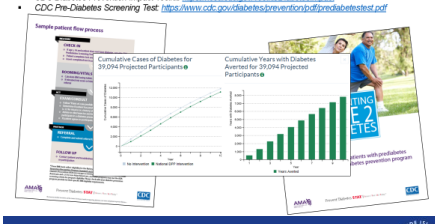
- A score of 9+ on the CDC Pre-diabetes Risk Test

Program Guidelines
- Led by trained Lifestyle Coaches in group sessions
- Meets once a week for 16 weeks, then monthly meetings for 6 months
- Cost: Free or minimal fee

Coordinated by RIDOH

National Diabetes Prevention Program (NDPP)

Resources
- *CDC AMA Provider Tool Kit:* https://www.cdc.gov/diabetes/prevention/pdf/STAT_toolkit.pdf
- *CDC National Diabetes Prevention Program Coverage Toolkit:* https://coveragetoolkit.org/
- *CDC Provider Resources:* https://www.cdc.gov/diabetes/prevention/lifestyle-program/deliverers/index.html
- *CDC Diabetes Prevention Impact Toolkit:* https://nccd.cdc.gov/Toolkit/DiabetesImpact
- *CDC Pre-Diabetes Screening Test:* https://www.cdc.gov/diabetes/prevention/pdf/prediabetestest.pdf



EnhanceFitness Program at YMCA

Group exercise program designed for sedentary adults that uses simple movements to improve physical strength, flexibility, balance, cardiovascular fitness, and pain management.

- Eligibility: 18 years or older
- 16-week program
- Cost: Free for members, $25 for non-members

Coordinated by the YMCA of Greater Providence

Matter of Balance: Managing Concerns about Falls

Teaches techniques to older adults that help reduce fears associated with falls by improving balance, increasing activity, and gaining confidence.

- Eligibility: Anyone 18 or older with concerns about falling.
- Small group led by a trained facilitator.
- Meets for 8 weeks, 2 hours per session.
- Cost: Free

Coordinated by Own Your Health

Powerful Tools for Caregivers

Allows caregivers to develop a wealth of self-care tools to reduce stress and increase effective communication with their dependents, loved ones, and healthcare providers.

- Eligibility: Anyone 18 or older who is a caretaker.

- Facilitated by two certified peer leaders in group sessions.
- Meets for 6 weeks, 1.5 hours per session.
- Cost: Free

Coordinated by Own Your Health

Tobacco Cessation Services

Provides a variety of quit smoking supports.

- **RI Smoker's Helpline (1-800-QUIT NOW):** Smokers call directly
  OR
  QuitWorks-RI (quitsworksri.org): Healthcare providers refer patients
- Eligibility: RI Residents aged 13+
- Multiple telephonic counseling sessions; Web & text-based resources; Nicotine Replacement Therapy (NRT); Follow-up reports to providers for Quitworks-RI referrals.
- Cost: Free

Coordinated by RIDOH and Healthcentric Advisors

Tools for Healthy Living - Chronic Disease Self-Management Program (CDSMP)

Helps people diagnosed with chronic conditions to manage their symptoms relevant to medications, communication with family and healthcare professionals, stress, nutrition, physical activity, and goal setting.

- Eligibility: Anyone 18 and older
- Led by two certified peer leaders in group sessions
- Meets for 6 weeks, 2.5 hours per week
- Cost: Free

Coordinated by Own Your Health

WISEWOMAN Program

Helps women improve cardiovascular health through risk reduction counseling and free lifestyle programs such as nutrition counseling, gym memberships, and medication therapy management.

- Eligibility: Women 30+ years old and eligible for the Women's Cancer Screening Program OR Women 30-64 years old and a RI Medicaid recipient.
- Offered at WISEWOMAN Program sites throughout Rhode Island
- Cost: Free

Coordinated by RIDOH

CHN – A Rhode Island Success Story...

The Story
- Former NDPP participant's success encouraged him to become a champion and help others.
- He became a trained NDPP Lifestyle Coach.
- His creativity and understanding of the risk factors for diabetes spurred him to outreach to a cohort of bus drivers.
- Under his coaching, one of these drivers was so successful, she is now an 'honorary spokesperson' who helps to market the program.

Takeaways
- One person's success can encourage others.
- There is a ripple effect.
- The outcomes of EBPs like NDPP have personal impacts on people's lives.

Thank you!

- CHN is a convenient way for providers to access valuable programs and resources to improve patient health outcomes.
- Programs under CHN are evidence-based and proven to improve clinical outcomes.
- Referrals can be made via fax, phone, or email.
- Professionally trained patient navigators contact and support referred patients by directing them to the most appropriate program(s) based on their health care needs.
- CHN is open to your feedback and is continuously working to improve the referral process for you and your patients.

IN A Nutshell

Kelsea Dixon
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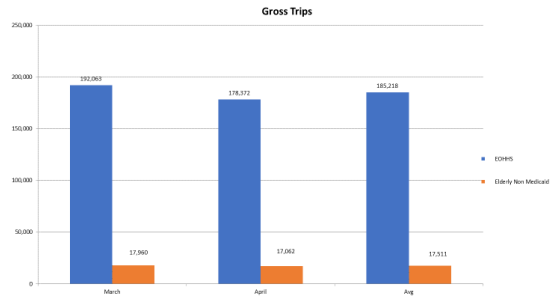
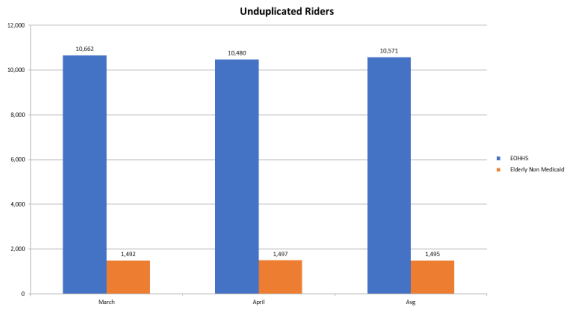
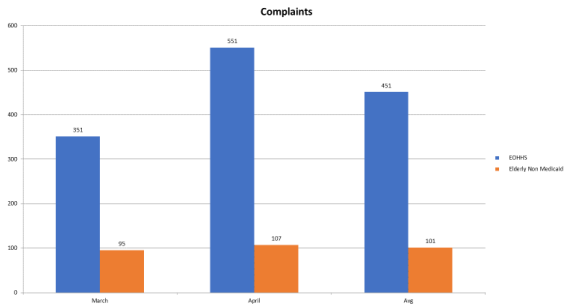
Division of Community Health & Equity
Rhode Island Department of Health
Kelsea.Dixon@health.ri.gov | 401-222-7623

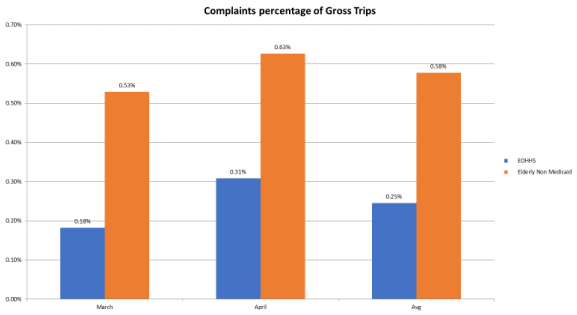
CHN Phone: 401-432-7217
CHN Fax: 401-633-6229
CHN Email: CommunityHealthNetwork@ripin.org
Calendar:
https://ripin.org/events/category/community-health-network/list/

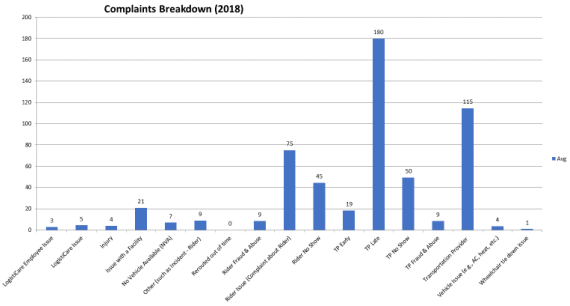
Transportation Report Slides

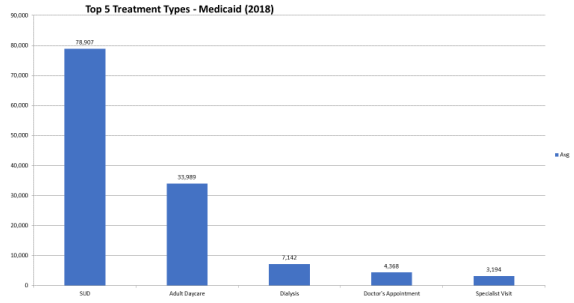


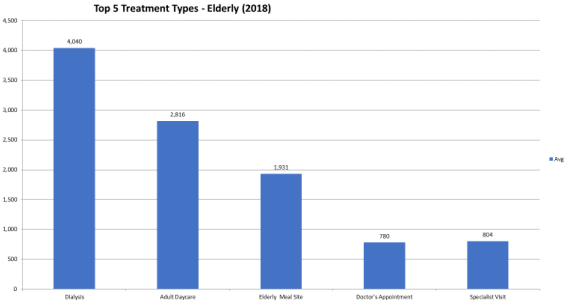














The Integrated Care Initiative Enrollment and Call Center Report

RI Executive Office of Health and Human Services

June 2018

Integrated Care Initiative Enrollment (June 2018)

Snapshot Enrollment by Program and Setting Compiled on the 1st of Each Month

	Neighborhood UNITY	Neighborhood INTEGRITY	PACE	Fee-for-Service	Total Eligible
Nursing Home	2,422	429	261	1,599	4,450
Community with Long-Term Services & Supports	1,093	1,298		1,255	3,646
Intellectual & Developmental Disabilities	887	1,218		474	2,579
Severe and Persistent Mental Illness	540	1,347		481	2,368
Community without Long-Term Services & Supports	7,497	9,131		4,197	20,825
Medicaid Only	710	-	24	317	1,051
Total:	**13,149**	**13,423**	**285**	**8,323**	**35,180**

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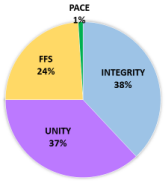
Integrated Care Initiative Enrollment (June, 2018)

Program Participation by Setting



Population	Neighborhood UNITY	Neighborhood INTEGRITY	PACE	Fee-for-Service
Nursing Home	54%	10%	1%	36%
Community with Long-Term Services & Supports	30%	36%		34%
Intellectual & Developmental Disabilities	34%	47%		18%
Severe and Persistent Mental Illness	22%	57%		20%
Community without Long-Term Services & Supports	36%	44%		20%
Medicaid Only	68%	-	2%	30%
Total:	**37%**	**38%**	**1%**	**24%**

*Numbers may not add up to 100% due to rounding

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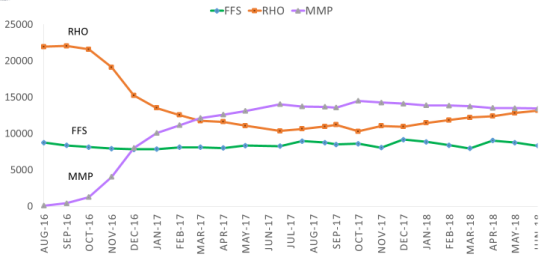
ENROLLMENT



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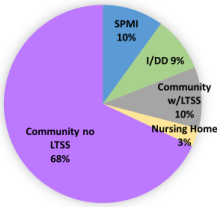
Neighborhood INTEGRITY (Medicare-Medicaid Plan)

Total Enrolled as of 6/1/2018



Cumulative Enrollment by Month

Population	April	May	Jun
Nursing Home	427	433	429
Community with Long-Term Services & Supports	1,296	1,297	1,298
Intellectual & Developmental Disabilities	1,219	1,218	1,221
Severe and Persistent Mental Illness	1,352	1,352	1,347
Community without Long-Term Services & Supports	9,209	9,179	9,133
Total:	**13,503**	**13,479**	**13,428**

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Estimate of Projected New Enrollments

Neighborhood UNITY (RHO)

Population	July 2018	Aug 2018
Nursing Home	98	73
Community with Long-Term Services & Supports	45	24
Intellectual & Developmental Disabilities	20	8
Severe and Persistent Mental Illness	26	19
Community without Long-Term Services & Supports	376	309
Medicaid Only	97	59
Total:	**662**	**492**

Neighborhood INTEGRITY (MMP)

Population	July 2018	Aug 2018
Nursing Home	-	-
Community with Long-Term Services & Supports	7	-
Intellectual & Developmental Disabilities	4	-
Severe and Persistent Mental Illness	2	-
Community without Long-Term Services & Supports	18	-
Total:	**31**	**-**

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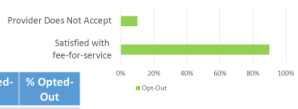
Neighborhood UNITY (Rhody Health Options)

May 2018 Opt-Out Reasons



Opt-Out/Disenrollment: Nov. 2013 – May 2018

Setting	# Ever Mailed	# Opted-Out	% Opted-Out
Nursing Home	8,870	1,408	16%
Community with Long-Term Services & Supports	5,391	1,401	26%
Intellectual & Developmental Disabilities	2,870	292	10%
Severe and Persistent Mental Illness	3,359	273	8%
Community without Long-Term Services & Supports	26,725	2,514	9%
Medicaid Only	1,642	174	11%
Total:	**44,691**	**6,592**	**15%**

May 2018

Total Calls: 50

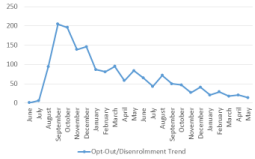
Total Opt-Out Requests: 22

Average talk time:
4:26
Average # of Calls Daily:
8

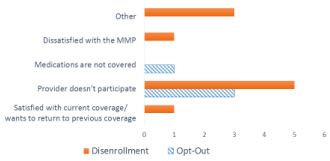
7

Neighborhood INTEGRITY (Medicare-Medicaid Plan)

Monthly Opt-Out/Disenrollment Trend



May Opt-Out and Disenrollment Reasons



8

Neighborhood INTEGRITY
(Medicare-Medicaid Plan)

Opt-Out/Disenrollment: July 2016 – May 2018

Setting	Total Ever Enrolled	# Opted Out/Disenrolled	% Opted Out/Disenrolled
Severe and Persistent Mental Illness	1,871	67	4%
Intellectual & Developmental Disabilities	1,519	74	5%
Community with Long-Term Services & Supports	1,920	163	8%
Nursing Home	1,105	143	13%
Community without Long-Term Services & Supports	12,555	635	5%
Total:	**17,962**	**1,045**	**6%**

Neighborhood INTEGRITY
(Medicare-Medicaid Plan)

Enrollment Line (Call Center) Statistics

Month	Total Calls Received	Total Calls Answered	Average Talk Time (minutes)
December 2017	389	389	6:40
January 2018	331	331	8:42
February 2018	311	311	9:40
March 2018	264	264	8:34
April 2018	339	339	10:37
May 2018	279	279	11:26

Enrollment Line (Call Center) Call Actions

Month	Disenrolled from INTEGRITY	Opted-Out of INTEGRITY	Educated Member	Enrolled Member	Transferred Calls
December 2017	39	2	188	22	136
January 2018	20	1	157	42	111
February 2018	20	9	147	39	96
March 2018	11	7	107	41	98
April 2018	19	2	152	88	78
May 2018	8	6	147	54	64

Neighborhood INTEGRITY (Medicare-Medicaid Plan)

Enrollment Line (Call Center) Application Processing

Month	Total Applications Received	Total Enrolled	Ineligible	Missing Information	Other*
September 2017	68	51	0	15	2
October 2017	115	87	2	26	0
November 2017	78	50	22	6	0
December 2017	58	29	23	6	0
January 2018	62	46	14	2	0
February 2018	65	43	15	5	2
March 2018	63	41	22	0	0
April 2018	133	109	18	6	0
May 2018	83	56	34	2	1

* Applications requiring manual intervention and later processed by EOHHS